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ABSTRACT

The development of a child psychiatric unit in a municipal, ghetto-located hospital is described. Initial problems and their solutions are discussed. Accepting the fact that the problems of the political scene and gross underfunding were uncontrollable, focus was put on devising a service comparable to those utilized by middle class populations. A team comprised of professionals and unprofessionals was expected to share primary responsibility for a client and his family throughout their entire contact with the service. Varied, multiple and experimental treatment procedures were used. The approaches included: (1) a medication clinic; (2) a learning disability evaluation clinic; (3) activity groups for young latency-age boys and pre-adolescent girls; and (4) behavior modification guidance to families. Conclusions and continuing expansion of programs and experimentations complete the discussion. (TL)

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THE DEVELOPMENTAL VICISSITUDES OF A MUNICIPAL HOSPITAL-BASED CHILD PSYCHIATRY UNIT IN AN URBAN GHETTO

Carol J. Eagle, Robert Shaw, John Tucker and Katie Eisenstadt

Developing a new child psychiatry unit is a difficult task. Developing a child psychiatry unit in a municipal hospital is a more difficult task. Developing a child psychiatry unit in a municipal hospital located in a poverty ghetto brings to light several unique problems which makes the task seem, at times, insurmountable.

Lincoln [1] is a city hospital affiliated with Albert Einstein College of Medicine and responsible for a catchment area of 375,000 people in the South Bronx. It is referred to locally as the "matadero" (slaughterhouse). The South Bronx competes easily with all statistical indices of severe poverty areas (e.g., in New York City; Harlem and Bedford-Stuyvesant) such as rate of infant mortality, venereal disease, short life expectancy, reading retardation, etc. Garbage overflows the gutters of the streets, abandoned cars are everywhere, junkies and pushers seem to be on every street and in all the school yards, abandoned buildings pose serious fire hazards and all of this physical decay and deterioration extends block upon block over a 6 square mile area. Lincoln sits at the edge of this area (next to an expressway) in its own squalor, looking far more like an 1890's prison than a building for health care.

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1. Lincoln Hospital is a general hospital with no in-patient psychiatric facilities. Under the affiliation grant, psychiatric facilities began in 1963 and were augmented by an NIMH community mental health center staffing grant in 1968.

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It was within this ghetto setting that we began to analyze our problems and determine the procedures to develop.

SPECIAL PROBLEMS

One major problem faced by the hospital located in the slum is that its facilities are inadequate. There is inadequate space, inadequate supplies and lack of adequate staff. In addition, it is very likely that the building itself is deteriorating and in disrepair resembling the surrounding tenements rather than the modern health plant that would be seen in middle-class neighborhoods. Through a process of absorption the ghetto, therefore, exerts its characteristics on the hospital rather than the hospital exerting its effect on its environment. This observation is so common that we are all familiar with complex medical centers operating several hospitals all in good to excellent condition but whose ghetto-located facility is neglected to a degree comparable to the discrepancy between a middle-class suburb and a poverty area. The professional working in this slum condition begins to feel his own sense of competence and self-worth undermined. He may initially attempt to alter his physical surroundings but comes up against "no funding" or "no resources." Before too long he has assumed the characteristic of the ghetto dweller in his belief that nothing can be done. This is reinforced every day by his contacts on behalf of his patients with the bureaucratic agencies who, sometimes, can even listen compassionately, but feel no ability to remedy.

The second problem to be faced is attitudinal prejudices, such as race, poverty and professional prejudice. Professional prejudice is seen when mental health workers, i.e., nonprofessionals join the staff. The professional may have a "honeymoon" period when he overinvests the nonprofessional with unusual abilities, or feels himself in the kindly role of someone who wants to teach and help out.

The professional is baffled when the nonprofessional reacts without gratitude, and, in fact, implies that the professional is treating him in a condescending, superior way. In addition, it is difficult for the nonprofessional to receive the respect and authority accorded the professional from service chiefs within the mental health service hierarchy itself and in negotiating with outside agencies on behalf of the children with whom he is concerned. This prejudice is inherently structured within the organizational hierarchy of the hospital or the service. That is, in any institution there is a good probability that the top level of the hierarchy will be white, middle-class and professional and the bottom level will be non-white (depending on the geographic area), and/or poor with limited formal credentials.[1]

Another prejudice is manifested in the low priority accorded children's needs in our country. The Joint Commission of Mental Health of Children states that, "in spite of the program and recommendations proposed in the 1930 White House Conference ...the care of the emotionally disturbed child in this country has not improved - it has worsened considerably." In our country's hierarchy of esteem and status children rank at the bottom along with non-whites, illiterates, alcoholics and addicts. This attitude might be called, in current parlance, "benign neglect." However, "neglect" for the developing child can never be "benign." Psychiatry, itself, reflects this attitude. As Rexford states: "Whereas the adult psychiatrist must cope with the ambivalence of other medical and nonmedical personnel, the child psychiatrist must in addition cope with the ambivalent attitudes of the <u>parent</u> profession."

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1. As appropriately put by Dr. Jack Wilder (Roche report); "a non-mental health organization is generally run like a big pyramid. It gets broader and broader toward the bottom, and finally there are a lot of people manufacturing or selling. My impression of many mental health facilities is that this is turned around. The apex is down below, consisting of one Puerto Rican who just flew over. He's seeing all the patients and everyone else is consulting with each other. One place had so many meetings that they had one meeting at the end of the week just to discuss the other meetings."

Despite the fact that at least 50% of a ghetto population are under 21 years of age, budgetary apportionments of mental health programs do not allot an equal share of monies to children and their families.

Intricately interwoven throughout these problems are the attitudes of racism and prejudice against poverty. Poor black and Puerto Rican children encounter special pre-formed and sterotyped attitudes on the parts of adults whether in the educational or mental health world. An IQ of 80 obtained on a white-standardized test corroborates and gives justification to labeling a child as "slow" or someone from whom we cannot expect too much. In reality, however, careful evaluation of such a child often reveals a picture of certain limitations, more often than not in the area of specific academic skills, than in intellectual capacity. Similarly, the mental health patient is too often labeled as emotionally disturbed, in a structural sense, before effort is made to understand what real life stresses he is encountering. Often such patients are exhibiting anxiety and depression reactive to their inability to maintain the flow of adequate vital supplies (see Caplan). These prejudices are not the sole province of the white professional but are also seen in the black professional who seems to take on the anti-welfare attitude of "if they worked harder they could make it."

Another problem is in store for the professional. He works with patients who rarely resemble the prevalent explicit notion of the "good" patient he has been trained to expect. Patient's requests for help are not made in the terms commonly identified as pleas for help, e.g. "motivation." The ghetto dweller has long lost any degree of optimism or positive expectation of help from an agency. Furthermore, the presenting problem is frequently disruptive behavior, a symptom which in any setting is very difficult to treat. The clinician whose patients are almost entirely from the welfare rolls thus experiences an even

greater threat to his professional self-esteem. This along with the other difficulties so far described result in an undermining of the clinician's confidence in both his adaptive and his clinical skills and produces in most new staff members a state of disequilibrium and anxiety, e.g. "cultural shock." De Sole and Singer divide the stages of this shock as: honeymoon, crisis, recovery and adjustment. The unfortunate part is that too often the professional resolves the crisis stage through withdrawal, either from the service itself or from patient contact, before he has the opportunity to move into stages of recovery and adjustment.

In addition, the urban ghetto hospital has its political problems in this day of community struggle for civil rights and community control. This was manifested within the Lincoln Mental Health Service because of the juxtaposing of nonprofessionals, from the community, with the more traditional white professional medical staff. Discrepant aspirations and goals stemming from these two sources led to discord, which, at times, can be constructive but, at other times, can lead to instability or disruption in program functioning.

As a result of these many factors staff positions are rarely sought after by the well established professional, who works in more pleasant surroundings with a greater sense of security. Therefore, it is likely, as in our situation, that the staff will be composed of junior professionals and nonprofessionals. Such an inexperienced staff requires special supervision and supports to cope with feelings of anxiety and fearfulness; otherwise they may seek refuge in withdrawing from actual patient contact.

Finally, underlying all of these problems is perhaps that of underfunding. The mental health services responsible to a population of 375,000

could not possibly provide comprehensive care with it budget, amounting as it did to perhaps $9.00 per person for a year. If figured conservatively, and taking the estimate of 30% of children needing some mental health intervention (refer to NYC study), we would have a population of 50,000 21 years of age and under to service. No wonder such programs are labeled as "tokenism".

Side by side with these problems, however, were certain assets. As is known, the ghetto-located medical and mental health facility has been free to develop its own pattern of functioning just as it is responsible for the maintenance of its own plant. This can lead to bad service as well as a bad plant, but in our case, we feel, it enabled us to innovate new approaches because there were few of the traditional constraints.

The impact of the problems, described above, on the professionals led to the corollary benefit that professionals who did not have the flexibility to entertain or explore new techniques because of their involvement in issues of status and reputation left the staff. That our staff was predominantly composed of junior professionals and nonprofessionals meant that they had not yet had enough experience or training to convince them that there was only "one true way" of helping people with mental health problems. They were free to experiment with different techniques and to switch from one approach to another when they saw they were unsuccessful.

Finally, our patients, in themselves, were an asset, coming to us as they did without any preconceived idea of waht we should be doing or what kind of treatment they should be getting. Based on their years of experience with agency contacts they anticipated so little from us that the attempts we made on their behalf elicited disproportional positive feelings on their

part of appreciation.

In this context of liabilities and assets, faced with an overwhelming service demand, we made the decision to develop a service to provide quality care to children and their families rather than a service predicated on providing a little something to vast numbers of people. We feel that the latter approach is too typically that given to poverty people, and we abhor the scene of endless waiting in waiting rooms, brief consultations with medication prescribed, lack of follow-up and all such approaches which can only be impersonal and dehumanizing. Our guiding principle, in contrast, was to establish services that would be of equal quality to those for a middle-class population.

Accepting that the problems of the political scene and the gross under-funding were outside our capabilities of coping with, we focused on devising a system that would effectively cope with the other problems. We did not want to succumb to the ghetto's characteristics or to the poverty families' disorganization or feelings of hopelessness and despair. We knew that to reach out in a truly meaningful way to the slum family we had to be flexible, we had to be able to operate in the "here and now" and we had to be oriented toward solving specific problems. At the same time we knew our internal organization had to be highly structured. And this was the technical problem we were faced with -- how to develop a rigid structure without sacrificing flexibility.

The problems posed by our staff composition of professionals and non-professionals was solved by pairing them in teams. We were sure that each had something to contribute to the other because it was our impression that the professional tends to focus on the patient's problems in terms of intrapsychic processes while the nonprofessional tends to focus on the problems as the reflection of

environmental stress. Due to space shortage they shared the same office, which seems to have been beneficial in terms of facilitating communication.

To combat attitudes and prejudices against the poor, and professional rivalry, the team was given and had to share primary responsibility for a client and his family throughout their entire contact with the service, and regardless of different treatment modalities brought in. The hallmark of our approach was to work with the total family, rather than with the identified patient, the child alone. We communicated to the family they had to face that the child's problems were a reflection of something gone wrong within the family's interaction itself and they had within their own system the means to solve the problem.

To combat the slum dweller's disorganization, apathy or inability to act like middle-class patients we invested in varied, multiple and experimental treatment procedures.

The teams were to think of treatment techniques as being available as though they were in a supermarket and could shop around for the best buys for their families' problems. Throughout this "shopping" the team would hold the responsibility for the ongoing care of the family and maintain their own contact with them.

The options available to the team are:

-- A medication clinic where the psychiatrist evaluates the appropriateness of the referral for medication and prescribes the proper medication. He takes care to educate the team in terms of reactions to the particular drug he had administered and also continues to evaluate the patient periodically through sitting in with the team in their sessions;

- - A Learning Disability Evaluation Clinic. Out of the work-up comes an educational plan tailored for the child that the team can carry out themselves or help the school to carry forward;

-- Activity groups for young latency-age boys and pre-adolescent girls. There is currently an ongoing Spanish-speaking mothers' group where better organized mothers are able to help other mothers with their child caring problems.

While the team makes use of these various methods, the family can continue in family treatment sessions. The family session consists of the total family and we, therefore, have put forth a great deal of effort to insure that the father will be there too. This treatment approach stems out of our conviction that the total family must be helped to re-structure their interaction to solve the problem they are facing. The team's effort as a change agent is to help the family discover within themselves their own abilities to cope with and handle their difficulty with the purpose of building in these coping techniques for future difficulties which might arise.

One of the approaches used in family sessions and taught to the parents is that of behavior modification. This technique results in rapid success in many families. This approach enables the therapist to introduce a structured relationship into the interaction between parent and child. In fact what may have seemed to be an ego structural problem may turn out to be a functional problem. We question now whether that which looks like ego disorganization in disorganized families is really an operational disorganization because when the impact of the behavior modification techniques are felt there no

longer appears to be the degree of disorganization in ego functioning seen before. There is also a transfer effect which some parents easily make. That is, the mother begins to apply the technique to problems she is having with other children or to other problems this child now presents. One notable success we had was with a mother who viewed her 6 year old daughter as so uncontrollable, so wild and so hostile she did not raise a hand to control her because of consciously experienced murderous impulses. By first demonstrating and then supporting her in techniques for those times when the child "went wild" or "opened her bad mouth" she began to exert her authority over the situation. The young girl began to respond in a more appropriate fashion and her behavior began to be shaped in a constructive fashion (see Bernal). An unexpected finding, however, emerged in our school visit. The school did not know of our involvement but had witnessed a dramatic change in this child's classroom behavior and writing skills. We had not known that this child (who was showing left-right disorientation and problems in perceptual-motor functioning, according to the teacher) abruptly began to print letters correctly and not invert or reverse them as she had been doing. She also began to show an interest in and an ability to read. The teacher dated this change without knowing that this was the very time we had introduced the behavior modification techniques.

In addition to the family sessions, or as an alternative plan, one particular member or subgrouping of the family might be seen in special sessions. Individual sessions with a child often utilize play therapy techniques or relationship therapy techniques like taking the child to the park or out for an after-school snack, etc. Important ancillary services are utilized. Ordinarily each family is sent to

Pediatrics for a medical check-up and where indicated, a neurological. Each child has a school visit conducted by the team with the mother with the relevant school staff. Home visits are made and this was found to be particularly important in the cases where behavior modification approach was the appropriate mode of treatment and specific techniques could be developed relevant to the issues at home. Also the team is actively involved in other agency contacts such as welfare housing and occasionally probation officers and/or the youth board personnel.

To combat feelings of fear and anxiety and the syndrome of "cultural shock" in our staff we developed a well organized and supportive structure for service procedures. Underlying the structure is our conception of the total clinical approach as an opportunity for ongoing in-service training. Intake interviews with the entire family are scheduled at regular times. Senior staff visit during the session and subsequently a conference is held to consider diagnostic issues and treatment approaches. Once a treatment plan is started a periodic review conference is held to evaluate the appropriateness of the approach. Staff attend these conferences conducted by the director and/or assistant director as a way for them to enlarge their understanding of the patient population and treatment approaches beyond their own cases. Besides regularly scheduled supervisory hours the senior staff hold an open door policy, that is, to be called upon at any time to help solve a problem.

Crucial to any effective service is feedback. Our review conferences provide the format for clinical case feedback, but in addition we built in

a monitoring system through the development of forms and record keeping. The forms were designed not only to succintly chart the flow of the treatment itself but also were designed for the purpose of training the staff to think in terms of diagnostic issues, goals to work for and evaluation of success and failure. In turn this data provided us with statistical facts so that at any time we would know the clinic's capacity and the clinic population.[1] Although we are currently in the process of using this material to evaluate our effectiveness, it is our initial impression that our families keep appointments and maintain continuity in their contacts with us to a degree unusual as compared to what has been reported by mental health clinics in similar poverty areas.

After a year of service we are able to draw certain conclusions. The first and foremost is the fact that the use of flexible and varied techniques by a team who is accepting the primary responsibility for a family leads to the involvement of poverty families with their own treatment commensurate, probably, with any middle-class clinic. Although we certainly had drop-outs and we had families who became uninterested in continuing after the particular problem was solved even though, in our judgment there were still other problems, it is our impression that our success is equal to that of clinics working with presumably more highly motivated patients. Thus, having a comprehensive armamentarium of treatment interventions and being able to change techniques when needed enabled us to maintain continuity of patient contact and involvement on the part of the family.

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1. Approximately 80 children are seen per month. Our turnover rate is on the average of 32 cases a month. Male children outnumber female children 3 to 1. The average age is 9 years. The typical problem is behavior disorder.

Through the contact with our families we were frequently able to see that what originally appeared to be structural disorganization or weakness was, in fact, functional. Once the family had been helped to institute new coping techniques, they demonstrated new capacities and abilities not evident originally.

It is also our impression that intense intervention over a short period of time is more profitable in the long run than prolonged contact on a less intense level. We are currently experimenting with this approach, that is, conducting family sessions for at least two hours, instead of the usual one; of making several contacts per week as opposed to just one. In other words, to move in quickly at the time the family is experiencing the most distress and to focus all efforts intensively on solution. This approach becomes a model itself for the family to emulate, when faced with problems.

The second conclusion is that nonprofessionals can occupy an equally important therapeutic role to professionals and in terms of current manpower shortages become a vast pool from which therapists can be drawn. The teaming of the professional and the nonprofessional has led to a complementation of each other's views and techniques so there is a greater breadth to the treatment. One of the more significant contributions of the nonprofessionals to the teams is their ability to help develop goals that are commensurate with the family's needs rather than the professional's idealized fantasy of what the family should want and if, indeed, not fantasy, a goal based on his own background and training. (It is a well known fact that training departments look for the "ideal" patient for its trainees -- a middle-class neurotic suitable for long-term psychoanalytic psychotherapy. Poverty people rarely qualify at this level of criterion) Thus, the nonprofessional provides an in-service training role for the professional. Similarly, the professional can contribute a greater sophistication of intrapsychic dynamics and psychological

processes to the nonprofessional. Together the team is able to provide skills ranging over the many varied problems we see and/or techniques we instituted in our patient population. A greater degree of competence has been experienced by both nonprofessional and professional and this has brought with it greater feelings of equality. This blend was achieved through the close supervision of all clinical activities by the senior staff. We, however, have not been able to solve a basic issue of equality and that is salary levels. The nonprofessionals are always paid two to three thousand dollars less than the least well paid of the professional disciplines, i.e. the junior social worker.

Our conception of the service as an in-service training program for all has meant that a critical and evaluative approach can be maintained. Failure can be viewed not as only the family's failure but also the failure of the approach or technique. This, in turn, strengthens our emphasis on flexibility and gives a spirit of adventure to each new problem. Similarly, building in monitoring techniques through record keeping and review conferences insures comprehensive care for the family as well as continuity.

All of this has not been accomplished without a great deal of growing pains. The most dramatic difficulty was between the professional and nonprofessional, or the have's and the have nots. At times they were almost paranoid about one anothers' intentions most commonly expressed through the feeling that the professional was trying to push off all the scut work on the nonprofessional; and the professional complaining that the nonprofessional was not taking a "professional" attitude of

responsibility. Underlying these accusations was the problem for the professional of the cultural and language barrier and the fear of being mongrelized. The nonprofessional with the same cultural and language problems had, in turn, the fear of becoming coopted by the establishment.

However, as the structure took hold and the training began to build feelings of competence the staff began to experience a growing awareness of their accomplishments. They could see themselves as agents who were reducing the common affliction of ghetto families, alienation and apathy. They could even, at times, feel they were successful in giving new motivation or aspirations to previously depressed and despairing families.

In spite of budget cutbacks and, therefore, staff cutbacks this service continues to keep up its monthly number of patient contacts. The mandate for the development of a child psychiatry unit within the mental health service has been carried out through the development of a core staff tooled to handle this population.

The population we have seen, as expressed before, varies from families with true emotional and cognitive disorders to families reacting to burdensome and overwhelming socio-economic problems. Thus, a child psychiatry unit should have within it the capabilities of handling all aspects of possible distress and problems families can experience. As Sonis states"...the mental health professions need to develop a better model and new pattern of services to provide the right kind of treatment, at the right time, and in the right place." The right kind of treatment,

at the right time and in the right place for many patients is reflected in the community-oriented model. This model must be backed up by a well-functioning clinic such as described above.

This model stresses the importance of establishing consultation, liaison and educational relationships with all aspects of the community. The clinical arm can reach out into the community through mobile crisis units and active liaison and coordination with children's in-hospital services for after-care. Community developers can work along side clinical teams so that when the clinical area becomes aware of a recurring problem in a particular area the community developers can be instrumental in developing community reaction to the problem and community solution. For example, school suspended children are an enormous problem because of the lack of facilities to help them. Not only should the clinic be concerned about the emotinal aspects of the child's problem, but the community and the school should be aided in facing this as their problem and within their jurisdiction. In addition to handling problems, this model envisions prevention as an equally valid approach. Not only do unwed teen-age mothers need pre- and post-natal psychological and emotional support and help but so do educational programs that have been established for unwed mothers. For every family and child interaction that has been aided in a more positive growth-enhancing direction, there are ripple effects from the immediate one of the parents to their other children to the larger arena of the neighboring community.

The solution to problems such as drug addiction and educational

Failure cannot be solved through studying the child alone but must take into account the child's environmental institutions and ecology.

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